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ABSTRACT

Research has shown that suicide risk is elevated in the patient who has tested positive for Human Immunodeficiency Virus (HIV). Studies within the Army have found that the three most turbulent periods for the soldier with HIV infection are: (1) at the time of notification of diagnosis; (2) when the family and peer group learn of the diagnosis; and (3) when there is concrete evidence of failing health. In response to the challenge of medical management of high risk patients, a multi-speciality ward program at Walter Reed Army Medical Center was designed to meet and to prevent anticipated suicidal behavior. The ward program seeks to: (1) create a therapeutic and facilitating environment for the HIV sero-positive soldier; (2) screen the HIV positive soldier for psychiatric conditions and facilitate treatment; (3) provide information about the infectious nature of the illness; (4) initiate twice-a-week support groups; and (5) transfer the acutely suicidal, depressed, or impulsive patients to psychiatric units. Self-destructive behaviors are quickly identified and addressed. The biopsychosocial approach to the HIV patients addresses the multifaceted nature of the condition. By anticipating stressors at the three crucial phases, suicidal ideation and behavior can be quickly detected and psychiatric symptoms treated. Based on subjective staff appraisal, the program appears to have worked. (ABL)

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A SUICIDE PREVENTION PROGRAM FOR HIV-POSITIVE PATIENTS

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According to Weisman . ... suicide prevention is a magnificent objective, (although) suicide has a refreshing appeal for some patients, exceeding what life has to offer them, and to try to prevent these people from destroying themselves is a little like preventing them from dreaming.... However, it is still mandatory that we search for ways to prevent suicide.... (1). It is our task to seek ways to intervene and develop programs that will effectively reduce suicidal behavior both in high risk individuals and high risk populations.

INTRODUCTION:

In October 1985, the U.S. Armed Services began testing all active duty personnel for evidence of infection with the HIV virus (the virus implicated as the cause of Acquired Immune Deficiency Syndrome)(2). The testing procedure involved an educational briefing about the HIV virus including how it was transmitted and the common risk factors for infection, i.e., sexual transmission, I.V. drug use or blood transfusion. Blood samples for HIV antibody testing was obtained and the soldier told that he/she would be notified if the test was positive. Shortly after the start of this testing it was discovered that soldiers, on learning that they tested positive, were experiencing severe psychological reactions including a high

frequency of suicidal behavior. These soldiers had been informed that they tested positive and had been counselled, as required by Department of Defense policy (2), regarding the progressive and infectious nature of their infection.

In January 1986, a soldier, who was at the Walter Reed Army Medical Center for staging and evaluation of his HIV infection, killed himself. This case brought to the awareness of the hospital authorities the severity of the emotional stress that these soldiers experience in the process of adjusting to the diagnosis of HIV infection. In an effort to provide a suicide prevention/intervention program, psychological support and appropriate treatment for the HIV sero-positive soldier, a specific Ward was established in Jan 1986 by the Commanding General at WRAMC.

The first step in suicide prevention is identification of those at high risk. By suicide prevention we mean prevention of successful suicide and reduction in self-inflicted injuries and self-destructive behaviors. There are numerous studies in the literature that describe those persons at high risk for suicide (3-8). The identification of risk factors known from previous reported clinical experience with the HIV positive population (9-19) became the nidus for a prevention/intervention program. The goal is to reduce suicidal behavior (i.e., suicidal threats, suicide attempts and completed suicide).

In the following sections we will describe some of the suicide risk factors and stressors we observed in Army HIV sero-

positive patients and the specific Ward Programs we designed to reduce the risk of suicidal behavior.

SUICIDE RISK IN THE HIV SERO-POSITIVE PATIENT

The possibility of suicidal behavior is best understood within a risk factor model. The risk of suicidal behavior is correlated with the number and severity of risk factors. The risk for suicide in the HIV sero-positive person is high not only because of the association of suicidal behavior with life -threatening illness but also due to factors known to be associated with AIDS, i.e., risk taking behavior, impulsivity, drug abuse.(20-22). For example, in the civilian sector, adolescent males with drug and alcohol abuse problems, depression and antisocial behavior are known to be at elevated risk of suicide (23-25). In a recent report (26) the risk or suicide among men 20 to 59 years old with AIDS was determined to be 36 times greater than for other men in that age group. Studies in the Army indicate that male suicides are correlated with recent loss of a love relationship, or when there is administrative or legal actions against them (27-32).

In addition to the legal predicament, the homosexual in the military carries a great risk of exposure and ridicule from "straight" soldiers. Homosexual behavior in the army is considered grounds for administrative separation and discharge from active duty. HIV sero-positivity seems to make it virtually impossible for the soldier to conceal his sexual identity and preference. In some instances there is exposure of a homosexual

life style and such soldiers are subjected to peer rejection, hostility and alienation. Physical assaults against such soldiers have occurred (33).

CASE REPORT: Pfc AA was a 27 year old Caucasian Baptist, active duty new recruit whose basic training was interrupted when his HIV testing results became known. He was transferred to WRAMC for medical evaluation. In the Medical Hold barracks (an open bed facility for soldiers), he displayed sexually provocative behaviors with peers and superiors. Information obtained from several sources indicated that he had a history of emotional distress prior to his military service. Pfc AA committed suicide a few weeks after returning from Christmas leave to visit his mother. Investigation subsequent to his suicide revealed that, on the night of his death, he had been distressed after a telephone call to his family, had suffered a "rejection" by his barracks' mates, and had been drinking heavily.

Pfc AA had several risk factors. He was HIV positive, (in 1985 this factor alone carried an estimated one hundred fold increase risk for completed suicide compared to the overall military suicide rate). Additional factors which increased this soldier's risk of suicidal behavior were deviant sexual behavior, peer rejection, risk taking behavior, alcohol abuse and threat of administrative action terminating his Army career.

RISK FACTORS ASSOCIATED WITH SUICIDE AND SUICIDAL BEHAVIOR:

The risk factors associated with suicide and suicidal

behaviors in the HIV sero-positive patient are: 1) Deviant sexual behavior in which the soldier is usually estranged from peers and family groups; 2) Threatened separation from the military because of overt homosexual behavior or behavior unsuitable to military life; 3) Alcohol and/or drug abuse. There is often a relapse into drug and/or alcohol use following the diagnosis of HIV positivity as the substance is used in an attempt to escape from the awareness of the stresses; 4) Clinical trait or mental disorder, i.e., anxiety or depression. Affective disorders are frequently seen in this group of patients; 5) Male youth are known to be at high risk for suicidal behavior (23, 24, 25). The young adult is most apt to experience the HIV diagnosis as a catastrophic threat to his unlived life.

The three most turbulent periods for the soldier with HIV infection are: 1) at the time of the first testing and notification when the patient first learns of the diagnosis; 2) when the family, work and/or peer group learns of the diagnosis; and 3) when there is concrete evidence of failing health and progression of the disease.

TARGET POPULATION:

The usual admission is the soldier who is undergoing initial evaluation or first restaging. We have an mostly males (90%), in their early twenties and of the rank of sergeant. Soldiers and their dependents from the Military district of Washington or the North Eastern United States Korea and Europe are sent to the Ward. We also serve retirees. Since its origin in Jan 1986.

there have been 550 admissions.

THE SUICIDE PREVENTION/INTERVENTION PROGRAM:

MISSION: The mission of the Ward is (1) to create a therapeutic and facilitating environment for the HIV sero-positive soldier who is admitted to WRAMC to be staged and evaluated; (2) to screen the HIV positive soldier for psychiatric conditions and to facilitate treatment; (3) to provide information about the infectious nature of the illness (instruction in safer sex practices); (4) to initiate twice a week support groups; and (5) transfer of the acutely suicidal, severely depressed or impulsively acting-out patient to the inpatient psychiatric unit.

The Ward provides a comprehensive evaluation and treatment program to address problems frequently encountered by the HIV sero-positive patient in the initial as well as later stages of their infection. The model used is based on a bio/psycho/social medical model and the underlying working concept is one of "wellness".

These high risk individuals receive a combination of treatments: crisis intervention, support groups, supportive psychotherapy, education about infection control and safer sexual activity. When indicated, psychotropic medications and conventional psychotherapies are used. Substance abuse is addressed through educational efforts, early detection and a weekly substance abuse education/treatment group.

PROGRAM: The Ward is a 42 bed Unit that is "self care" and the patients are ambulatory. The Unit is under the direction

of the Infectious Disease Service of the Department of Medicine. The Ward Officer is a Family Practice Physician. The Psychiatrist acts as Assistant Ward Officer and acts as a Consultant to the Unit as well as providing direct care when indicated.

SCREENING PROCEDURES: All patients, on admission to the unit, are evaluated for suicidal risk, psychiatric disorder and have an assessment for organic impairment. Complete medical evaluation includes lymphocyte counts and anergy panel. Neuro-Psychological Testing includes cognitive assessment, evaluation of depression using the Beck and Zung Scales, Finger tapping test, Trails Test, and problem solving test are used. Social Service Assessment includes evaluation of support systems as well as Discharge Planning. Art Therapy Diagnostic Evaluation provides diagnostic information and serves as an introduction to Art Therapy. Every patient has a Drug and Alcohol Abuse Assessment using the MAST test. Referral for additional treatment to the WRAMC Drug and Alcohol Treatment Programs is made when indicated. Drug abuse is viewed as a health problem and abstinence is promoted.

EDUCATION: Information is given on an individual basis and in discussion groups pertaining to safer sex practice and for health maintainence and infection control. Family members who are at a risk for exposure to the virus are actively encouraged to be tested and evaluated. Preventive Medicine Consultation is routine for notification of patient's sexual partner or others at risk. Informational updates on treatment and research on HIV are

given regularly to allay anxiety and to help the patient assume responsibility for their care and treatment. Group meetings are open to out-patients through the "After-care" (Alumni) program that is held on the Unit.

TREATMENT: Each patient is assigned to an Infectious Disease Medical Specialist who has responsibility for the overall management of the patient's clinical care. In addition to treatment of the HIV infection, a broad range of psychosocial interventions are available to the sero-positive soldier depending on the evaluation of his/her psychological state and social support system. Psychosocial treatments may include crisis intervention, individual psychotherapy, family interventions, consultation with command, and informational/educational meetings in various formats. The stressors are identified and resources are mobilized to help the patient cope with his or her life crisis. The expectation is that the patient will master the life crisis with the support of family, other patients, friends and staff.

Milieu therapy is facilitated by weekly community meetings of all staff and patients; a structured weekly program and a daily morning patient-staff meeting to brief patients on their schedule and appointments for the day. Of greatest importance is the acceptance and commraderie that occurs among the patients and an informal buddy system has developed. Patients are involved in creating a support network among them selves, sharing information about resourses.

Values clarification and spirituality issues are addressed by the Unit's Chaplains in a weekly meeting. Art Therapy is available on a daily basis and facilitates the patient's identification and working through of feelings and reactions (often unconscious) that are evoked by the HIV diagnosis and screening process. In addition, a weekly " Imagery" group facilitates the patient's development of coping mechanisms and positive attitudes toward their illness. Group and Individual therapies deal with target issues of guilt, social isolation, stigmatization and hopelessness.

STAFFING ISSUES:

There are weekly meetings held with the Ward Officer, Psychiatrist, Chief of Infectious Disease Department and representatives of Social Work Dept, Preventive Medicine Dept. These meetings are for updates on policy and procedures and to discuss problem cases and staffing issues. In-service conferences are held weekly to update on relevant issues in clinical management. Countertransference problems are frequent involving feelings of anger toward those patients with deviant or unusual life styles; hostility toward patients who are dependent, without motivation or who enjoy the secondary gain of a medical retirement. Patients with substance abuse problems or whose recent behaviors earned administrative action, generate negative responses from the staff. Patients who do not practice infection control generate feelings of despair and destain.

RESULTS: During the first 18 months of operation, the special

unit had 550 admissions. There were no completed suicides and rare suicidal behaviors. Suicidal ideology, depression and substance abuse were symptoms that were quickly identified and treated with the result of a stronger therapeutic alliance and rapid amelioration of symptoms. Relapse of psychiatric symptoms before the scheduled six or three month return was usually the harbinger of more severe depressive or characterological symptomatology.

SUMMARY: In response to the challenge of medical management of high risk patients, a multi-specialty ward program was designed to meet and to prevent anticipated suicidal behavior . Based on subjective staff appraisal, this form of "mental health primary prevention" appears to have worked. Currently we are beginning to evaluate our program using empirical measures. Two completed suicides of HIV positive soldiers were not connected to our treatment population.

Our own tracking efforts show that two soldiers recently treated on our unit were hospitalized for suicidal behavior and are in treatment. There have been no subsequent completed suicides and the amount of suicidal behavior and self inflicted injury has been dramatically reduced, i.e., drug and alcohol use while hospitalized, suicide attempts while in the hospital.

Self-destructive behaviors of any magnitude are quickly identified and addressed. The biopsychosocial approach to the HIV sero-positive patients addresses the multifaceted nature of the condition. By anticipating the severe stressors at the three

crucial phases of HIV infection, suicidal ideation and behavior can be quickly detected. Acute psychiatric symptoms likewise can be recognized and effectively treated with psychotropic medications and psychotherapy.

Medical programs that include attention to psychosocial issues gain greater patient/staff satisfaction (34). In addition, countertransference issues, staff stress and burnout can also be addressed in the context of a multispecialty unit. The underlying concept of "wellness" and promotion of adaptation unifies the talented, multidisciplinary staff.

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